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Is the Culture Always Right?

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Recently there has been a critique of the use of western models in the trauma field. In this article it is discussed whether some of this critique reflects a continuation of a denial of trauma and PTSD that has been evident in psychology and psychiatry for a number of years. Although the critique has rightfully pointed out the importance of social and political dimensions in the understanding of trauma, it is argued that some aspects of trauma are universal. The critique has also focused on the use of western models of therapy in non-western societies. However, work done in this field has often adopted a community-based model focusing on large groups of people affected by war situations, not using medical therapy models, thus the critique has been somewhat misplaced. Especially in helping children in war it is important not to accept the culture too much and to rely on children's inborn resilience and cultural traditions for preventing long-term traumatic stress.

KEY WORDS: Trauma field, PTSD, Western models of therapy, Non-western societies, War, Children, Culture, Traumatic stress

Denial of Trauma

Denial of trauma and PTSD is a phenomenon that has been evident in psychology and psychiatry for a number of years. Solomon (1995) points out that this denial is not isolated omissions or distortions, but a pattern that spends over time, crosses national and cultural boundaries, and defies accumulated scientific knowledge. Van der Kolk, Weisaeth and van der Hart (1996) talk about the periodic denials or amnesia for psychic trauma within psychiatry where hard earned knowledge is lost and then subsequently rediscovered.

In no area is this denial more evident than when children are traumatized. It has taken centuries for the professional world and public to recognize that a large number of children around the world are both physically and sexually abused. Recently the «False Memory Syndrome Foundation» gained force and may have lead parents and children to refrain from presenting abuse (see Pope, 1996). Following adverse events, studies have shown that parents, teachers and other adults underestimate the intensity, magnitude and longevity of children's reactions to adverse events (Yule & Williams, 1990; Zivcic, 1993). One may therefore question reports that solely rely on information from adults following such events. In interviewing children in Iraq following the Gulf war three times in the years following the war, we learned from these children that they had stopped talking with adults about their intrusive images and thoughts because they felt that adults did not understand them, or just told them to forget about their experiences (Dyregrov, Gjestad, Raundalen, 2002). There was a strong adult denial of the painful material children struggled with, often as a consequence of adult's problems with dealing with their own traumatic after-effects from the war.

Besides parental denial, we have come across another form of denial of trauma. This takes place within UN agencies and non-governmental organizations. It can have a disguised form or be more outright. We believe that this denial is a mechanism that protects international aid workers, politicians and the international community at large. When the international community is unable and helpless at preventing atrocities and massacres in war situations, it becomes important to reduce the feelings of helplessness, impotency and guilt that such

situations create. Societies lack the capacity to deal with the ramifications of the traumatic events they produce. Collective guilt may be intensified among politicians and the world community at large if we all were to acknowledge the pain and suffering we directly or indirectly are unable to protect children from.

What is even more disheartening to experience is that respected professionals within psychiatry and psychology inadvertently support this denial of trauma. Professionals can unintentionally come to produce the ideological background for the widespread denial of trauma in children following war, and prevent adults from taking responsibility for promoting physical and psychological recovery and social re-integration of child victims of armed conflict, as proclaimed in article 39 in the Convention on the Rights of the Child. If the international community is able to say that children are not traumatized, and that the natural healing systems within their culture, as well as children's inborn resiliency, will heal their emotional wounds, then we don't have to assume responsibility or we can do away with our guilt feelings. Public investigations of traumatic events legitimize private memories, help memorialize them, and contribute to the healing process (Apfelbaum, 2000). Documenting the effect of trauma through research, in another approach that can help in recognizing people's plight and legitimize memories.

The Export of Western Models of Trauma

The new form of denial of trauma in war-afflicted populations is evident in the critique of the use of western models in the trauma field. Professionals in relation to responses to war and atrocity in general have voiced this criticism (Bracken, Giller & Summerfield, 1995; Summerfield 1995), and for war traumatized children in special (Hundeide, 1995; Tolfree, 1996). Bracken et al. (1995) present some sound arguments and raise important objections against applying western concepts in other cultures. They point out that it may be wrong to focus on the individual in cultures where symptoms and signs of trauma may have different meanings. They also question the relevance of western models of therapy used in societies that are less egocentric. They rightfully state that:

> If we are not aware of the biomedical emphasis which is at the heart of much of modern psychiatry and the assumptions underlying such an approach, we can all too easily end up imposing an inappropriate understanding of trauma which cannot deal with important social and political dimensions» (Bracken et al., 1995, p. 1081).

They go on to question the use of models of therapy that demand expertise, training and a new «language» that then will create a new expert syndrome that undermine already existing medical and non-medical approaches to the alleviation of distress caused by organized violence.

There are important dimensions that need to be discussed here. The first is whether there are professionals that advocate the use of trauma therapy after war situations in non-western cultures. For years others and we have introduced trauma concepts within UN organizations and other non-governmental organizations because such concepts increase the understanding and awareness of the effects that war can have on children and adults on all continents. When Summerfield (1995) describes that various aid agencies decided that counseling was a priority in Rwanda we question the validity of this description. It seems easy

to present this as the case, and then to voice critical remarks. However, to our knowledge, few if any agencies have advocated the use of traditional trauma therapy methods applicable only in a western society with an intact infrastructure. In fact professionals with a background from trauma, have argued for a demedicalized model of helping, emphasizing that normal reactions ensue from abnormal situations. This is in contrast to a psychiatric tradition prevailing in certain countries in the Middle East and also in Africa, where a traditional medical model with emphasis on medication is found. Instead of using a therapy model that obviously cannot reach the masses exposed to traumatic events, the approach taken has been to use knowledge about trauma and trauma alleviating methods and introduce this in schools, kindergartens, and orphanages etc., utilizing existing cultural and social traditions (Dyregrov & Raundalen, 1996).

Although we have not advocated a treatment model in Rwanda, others have pointed out that even when adhering to a treatment approach, it is possible to be sensitive to the culture:

> Within the context of PTSD-focused treatment, there is plenty of room for therapeutic strategies that are culturally sensitive and that incorporate specific treatments for individuals from specific ethnocultural backgrounds» (Marsella, Friedman, Gerrity & Scurfield, 1996, p. 536).

Goenjian and coworkers (1997) have shown that even a very western-based group and individual psychotherapeutic approach instigated to help early adolescent survivors of the Armenian earthquake showed a robust effect in alleviating posttraumatic stress symptoms and preventing the worsening of depression. However, there is no disagreement that trauma must be viewed in its social context or that a sole focus on the individual may lead to a disregard of the political system and other causes that produce violence. But children are hurt just the same, and if we apply our knowledge of trauma through methods based on both cultural healing mechanisms and western methods that can be tailored to the culture, children can be helped. This demands that one work closely with national counterparts to secure a sensitive application of methods, as well as a mobilization of the cultures' own natural healing systems.

Culture can buffer its members from the impact of stressful experiences (deVries, 1996). It can create meaning systems that explain the causes of trauma, provide rituals and healing strategies through which one can express and heal one's reactions and at the same time reconnect with the group. But sometimes the societal mechanisms for healing are rendered useless by the conflict at hand. Traditionally in Rwanda, the church would be important in meeting a crisis situation. As many of the survivors viewed the church to have «blood on its hand», the use of religion and the church was more difficult than before. There are some war situations that are so unprecedented (i.e. massacres) that no cultures have societal healing or coping mechanisms to apply. In such situations we often see the use of denial and repression as desperate mechanisms to ward off the magnitude of the events. Sometimes the introduction of new societal mechanisms can be helpful in such situations, such as the «week of expression» initiated by UNICEF and used in schools, orphanages and centers throughout Rwanda after the massacres in 1994.

Accepting the Culture

There is a risk that we too easily accept the culture and become too culture-relative to see that trauma in children is denied across many cultures. Those who criticize the use of

trauma concepts to understand and help children in these circumstances, often highlight the notion that culture has its own healing mechanisms, and that by introducing foreign (concepts) we run a risk of breaking down the natural healing mechanisms of the society. But such respect for the culture overlooks some cruel facts. Culture is not always right. In Africa the culture has produced one massacre after another. It has led to a breakdown of the social fabric and to ethnic and political conflicts in countries such as Rwanda, Burundi and Zaire. In our part of the world our western culture has brought us the atomic bomb, laser-weapons, surgical bombing, chemical warfare and McDonalds that spread to all corners of the world. If negative products of culture had not been challenged, we would still have denied sexual and physical abuse and exploitation of children world-wide, many of our taboos would continue to work as before, women would have no voting rights, and we would go on denying children the right to information concerning loss and trauma. During massive upheavals, the culture will have to develop new strategies to deal with what is at hand. Although prevailing and accepted strategies still may be useful, new strategies can be built on or integrated with old ones. Many of the trauma self-help strategies proposed in modern trauma work for children will easily be adaptable across cultures, as for example exemplified through the Children and War manual developed by Smith and coworkers (1998). This "new" knowledge is distributed through accepted and functioning structures, such as schools, and may be diffused through and connected with symbolic places such as churches, mosques and places where people gather. The new trauma knowledge may also be useful in explaining the reactions that individuals experience in the aftermath of trauma, although the wider meaning of the event(s) will be interpreted and understood on a cultural or spiritual level.

There are worldwide adult mechanisms of denial of trauma in children in most, if not all, countries in the world. In most cultures there is tension between opposing views concerning open communication with children about painful subjects. On one side there are those who argue for open, honest communication with children, and on the other side those that want to limit or protect children from communication about such subjects. Women often are representatives for the «open» approach, while men usually represent the «denying» forces. In Iraq we experienced that mothers were much more open to talking with their children about traumatic memories than fathers. In most cultures, there also is more tradition for openness in cities that in rural districts. When we decide to stimulate openness we usually support already existing forces within the culture that work to change prevailing attitudes of restricted communication with children.

It is dangerous to «accept» the culture too much. Many cultures have traditions that limit the life quality of people across the life span. Repairing the social fabric and providing security does not necessarily heal a distorted mind, but it is an important foundation for healing to take place.

Using Insights from the Trauma Field

Although one uses western insights gained in how traumatic events and traumatic loss affects people, one does not (and should not) have to use western methods of intervention and trauma therapy. While there is nothing wrong with using the concepts of trauma, diagnosing PTSD is almost meaningless in many countries, because individual treatment is not feasible. It would be unwise, unethical and impossible to introduce western individual or family trauma therapy in Rwanda. But it may be possible in parts of former Yugoslavia. In Rwanda there

were only a couple of mental health professionals alive following the genocide. The absence of professionals, the historical tradition and the magnitude of the massacres and traumas made it impossible to even think in such western terms. But we can apply trauma knowledge, and we can introduce simple self-help methods, ways of expression, writing, dancing and methods that may contribute to the alleviation of distress. Such methods can be spread through mass outreach efforts and reduce some of the traumatic after-effects that continue to affect children over time.

While what will be regarded as traumatic may vary across cultures, i.e. recently Terheggen, Stroebe and Kleber (2001) found that the highest ranking traumatic event in Tibet was "witnessing the destruction of religious signs", it may be a myth that there is such diversity in symptom expression in trauma survivors across cultures. In a study of Cambodian survivors of childhood trauma, Hubbard, Realmuto, Northwood & Masten (1995) conclude:

> The similarities in symptom expression and diagnostic overlap in this and other samples of childhood trauma survivors provide further evidence that, despite differences in culture, age, and stressors, human responses to trauma appear to be remarkably consistent» (p.1172).

In the most comprehensive book about ethnocultural aspects of PTSD to date, Marsella et al. (1996) write in their concluding chapter:

> It should be noted, in this regard, that trauma seems well understood by people from non-western cultural backgrounds, as noted throughout this book, even in the face of variations in concepts of health and healing» (p.533).

Although trauma takes place in a cultural context, individuals will experience it. There is reason to believe that there is a universal biological response to trauma (see Marsella et al., 1996) where at least the reexperiencing and arousal symptoms have a biological basis. Dyregrov, Solomon and Bassøe (2000) have described what they call a mental mobilization system working to secure survival in threatening situation. Parallel with the bodily activation in such situations, the brain rapidly searches through stored (previous experience and learning) and incoming information, to be able to make decisions about what to do. All sensory systems are sensitized to incoming information concurrent with a focusing on aspects of the situation deemed most important. Emotions are often put on hold (or dissociated) to secure that the processing capacity can be fully used for the situation at hand. The information taken in during these situations are often memorized more sharply than more neutral events to secure a proper response if faced by a similar threat in the future. Such response systems have universal survival value. Brutal events override ethnocultural variations (Marsella, Friedman & Spain, 1993).

While immediate reactions to trauma seem to be similar in different parts of the world, culture to a larger extent will determine reactions over time. Cultural belief-systems and practices may influence both traumatic after-reactions and grief reactions, i.e. the belief in the presence of one's ancestors. Indeed, some trauma reactions, like avoidance and numbing, may be very susceptible to influence from the prevailing culture. We agree with Marsella et al. (1996) who state:

> ...we believe that ethnocultural settings in which avoiding and numbing behaviours are more common expressions of distress are those ethnocultural settings in which PTSD prevalence rates will be highest» (p.534).

There is a need for better understanding of how trauma reactions may differ in non-western cultures, especially the frequent somatic expressions of distress (Hauff & Vaglum, 1994). This demand that we work to develop new or revise old instruments to better tap expressions of distress particular to various cultural groups. Manifestations of distress that in the western culture will be interpreted (and diagnosed) as signs of PTSD, may also be misinterpreted without knowledge of the culture. Eisenbruch (1991) has shown how culturally normal signs of bereavement may mislead a western clinician to think a person is psychotic or suffer from PTSD. The problems of the person may respond quickly to appropriate intervention by local healers. Although western methods may contribute to healing, they will usually be a supplement to the cultural healing mechanisms, more than a substitute. The cultural healing mechanisms have the benefit of generation's accumulated belief in its helping value, adding a significant placebo effect. But let us also acknowledge that the practice of healers can have negative effects. When the expected effect is not produced, the healer often blames the victim. In a training course we held for healers, this issue was specifically addressed to prevent such blaming. Healers were eager to learn and discuss such effects, and wanted to adjust their practice and stop blaming.

Approaching Painful Material

Hundeide (1995) has voiced another critique of cultural insensitivity by western professionals. He focuses on the danger of approaching and opening up for feelings in relation to traumatic events. His critique is based on an old-fashioned model of how one actually works with trauma, and disregards the common finding in trauma and grief research that shows that it is when adults refrain from letting children talk about their worst experiences that problems often continue.

A direct approach to talking about the traumatic experiences makes it possible to share thoughts and feelings with others, to organize thoughts, as well as making implicit memories explicit. Although not directly comparable, this echoes the findings in a report on therapy for sexual abuse where the authors state:

> The present study lends support to the view that, in young children who have already reported sexual abuse and have had some form of independent validation of that report, therapy that directly addresses sexual abuse-related issues is more effective in reducing symptomatology than therapy in which the child is not required to (and frequently does not) directly discuss the abusive experience (Cohen & Mannarino, 1996, p.49).

Hundeide postulates a Freudian regressive model and then go on to criticize this model as if this is used in modern trauma approaches. He portrays the help given in these instances as short-term professional expert assistance, a position far removed from the way that trauma aid usually is introduced in many countries. In most instances it will be caretakers in the child's natural community that helps children express, in the wake of terrifying war events that children have lived through. This is not comparable to expression in therapy following years of repression. Caretakers are taught how to help children over time, often with suggestions for setting aside a special time to express each week. It is not a «hit and run» approach, but building mechanisms that let the child know that it is possible to talk with sensitive and caring adults about what happened, and learn strategies that can help them reduce their distress.

To be able to understand the effect that war situations have on children, it has been necessary for us to talk to children while visiting war torn countries. This forms the basis for the helping projects, and it documents the effects of trauma. This documentation is necessary to raise awareness for the problems children face. Usually local professionals or sensitive caretakers can continue the process started in such interviews. Often we have returned to the same group of children several times, both to follow up on these conversations and to hear how they felt after the interview. Although some children state that it was very painful to talk about these events, many describe how they felt much better afterwards. Such positive evaluations of research interviews are known from other areas (Balk, 1983; Dyregrov, Dyregrov & Raundalen, 2000; Reich & Kaplan, 1994). Terr and co-workers (1996) reported that children who following the Challenger disaster had no other intervention than the opportunity to participate in a research interview reported fewer symptoms in a follow-up interview than children who had not been previously interviewed.

Research interviews with children can be painful, sometimes therapeutic, but the results usually make it possible to inform or persuade politicians and organizations to provide needed intervention. Another more serious issue is the fact that in some war situations such interviews may be seen as threatening to the warriors. This demands that great care must be taken to protect or provide security for those interviewed, if not, interviews cannot be undertaken. In such situations the validity of the results will also be questionable (see Rousseau, 1993-94).

Hundeide emphasizes that the natural healing mechanisms of the culture, i.e. social activities, rituals and institutions will lead to healing of trauma by itself. This «culture is always right» school where one believe that introducing the concept of trauma and trauma help is in disregard of the culture, can easily act as a reinforcer of the denial of trauma. Those who apply trauma concepts to war traumatized children are usually well aware of the cultural dimension, and they do not follow a medical model as postulated by Summerfield (1995). The model used is a psychosocial assistance model that uses trauma reduction procedures as part of a mass outreach model. Healing mechanisms already part of the culture is also utilized, i.e. prayer and telling your story to God or Allah.

We believe that the reduction of posttraumatic problems that otherwise can darken the life of a child is a very important task. Without understanding the traumatic effects we may also be ignorant of the contribution that trauma might have to the repetition of violent cycles, i.e. the participation in violence and massacres by adults who were traumatized as children. Although an area not well researched, we know that the propensity for violence is increased in victims of violence. In Rwanda there are anecdotal reports that child victims of previous massacres have been central as perpetrators in new massacres. War may make children more vulnerable to political forces that instigate violence.

Children as Resilient

Nowhere is it more important to question the stereotype presentation of children as resilient more than in the war area. This is not to say that a majority of children end up as psychiatric casualties, but many continue to live with various posttraumatic problems that affect their functioning (Dyregrov, Gjestad, & Raundalen, 2002, Dyregrov, Gupta, Gjestad & Mukanoheli, 2000). Eisenbruch (1988) writes of those who have been terribly brutalized or victimized who can find fresh initiatives in new countries and turn the state of passive suffering

into active conquest of inner sadness and outer uncertainty. But he also states «Perhaps the stereotype of the resilient, adaptable child refugee, inured to stress, is reinforced by examples such as these» (p. 284). He goes on to mention that the conventional wisdom that uprooted children adjust more readily than adults may lead to early signs of dysfunction being overlooked. This is true not only for refugees but also for those children who remain in a war-torn country.

Culture is not static; it is a dynamically changing entity. We influence other cultures, and other cultures influence us. Chinese and Asian medicine has become part of the American and European health cultures. Silver & Wilson (1988) have used American Indian purification and healing practices in the treatment of PTSD. In Bergen, a remote part of the world, we have our own shaman, influenced by African practices. We should be aware of how we can influence cultural change, but not be afraid to try to make a difference when aspects of a prevailing culture negatively affect children, nor should we adopt cultural practices uncritically. But at the same time we need to be very aware of the relativity of what we look upon as «negative aspects of a culture». We should continue to improve our research methods, scrutinize our findings and be open to new therapeutic advances, but we should never forget that history repeatedly has shown us that we as adults have overlooked, disregarded and denied the pain and suffering of children.

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